Jerry E. Abramson
Mayor

26 Member
Metro Council

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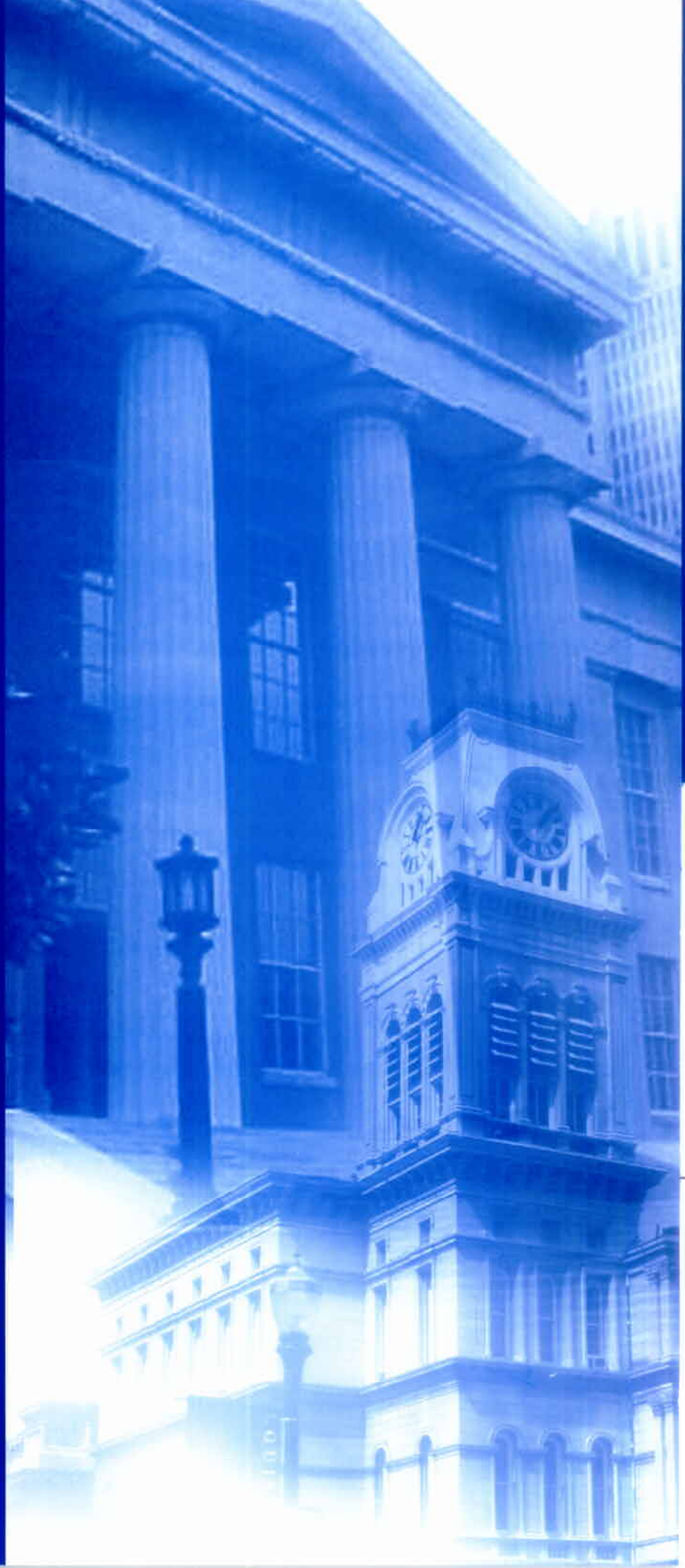

Office of Internal Audit

Health Department

Billing and Collection (Follow-up Review)

Audit Report

Health Department

Billing and Collection
(Follow-up Review)

June 2005

Table of Contents

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PRESIDENT, METRO COUNCIL

LOUISVILLE, KENTUCKY
OFFICE OF INTERNAL AUDIT

MICHAEL S. NORMAN, CIA
CHIEF AUDIT EXECUTIVE

Transmittal Letter

June 16, 2005

The Honorable Jerry E. Abramson
Mayor of Louisville Metro
Louisville Metro Hall
Louisville, KY 40202

Re: Follow-up Review of Health Department Billing and Collection Activity

Introduction

We examined the operating records and procedures of the Health Department's billing and collection activity. This was a follow-up review to the 2003 audit (report issued December 2003). The primary focus of the audit was the operational and fiscal procedures used to provide an accounting of activity (e.g., services delivered, patients served, billings sent, amounts collected). A secondary focus was the corrective actions implemented since the 2003 audit. Billing and collection activities conducted by the Environmental Health Services Division or at the MORE clinic were not included in this review.

Our examination was conducted in accordance with Government Auditing Standards issued by the Comptroller General of the United States and with the Standards for the Professional Practice of Internal Auditing issued by the Institute of Internal Auditors.

As a part of the review, the internal control structure was evaluated. The objective of internal control is to provide reasonable, but not absolute, assurance regarding the achievement of objectives in the following categories:

- Achievement of business objectives and goals
- Effectiveness and efficiency of operations
- Reliability of financial reporting

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- Compliance with applicable laws and regulations
- Safeguarding of assets

There are inherent limitations in any system of internal control. Errors may result from misunderstanding of instructions, mistakes of judgment, carelessness, or other personnel factors. Some controls may be circumvented by collusion. Similarly, management may circumvent control procedures by administrative oversight.

Scope

The operating procedures for the billing and collection activities were reviewed through interviews with key personnel. The operational and fiscal administration of activity was reviewed through tests of sample data. In addition, the prior audit report was reviewed to determine the status of corrective actions. Billing and collection activities conducted by the Environmental Health Services Division or at the MORE clinic were not included in this review. The details of the methodology and scope of the review will be addressed later in this report. Our examination would not reveal all weaknesses because it was based on selective review of data.

Opinion

The Louisville Metro Health Department should be commended for the efforts made in addressing the prior audit issues. The Office of Internal Audit has been kept apprised of Health Department actions since July 2004. Health Department personnel have demonstrated a commitment to having a sound control structure for billing and collection activity, and were cooperative during this review.

We are pleased to report that progress has been made in addressing several items noted in the prior review. However, there are still issues that are impacting the effectiveness of the billing and collection activity. These issues are segregated into two distinct areas.

1. Workflow Process – External

These issues are attributable to external factors, which limits the ability of the Health Department to control / address them. The internal control structure for these areas is inadequate. These are more systemic and ingrained, and are severely impacting the billing and collection activity. The external issues are as follows:

- **Patient Services Reporting System (PSRS).** This is the State administered system used for billing and collection activity. There are several issues associated with it, including that it does not have all the functionality of an accounts receivable system.
- **Payor Issues.** Multiple parties are responsible for paying for Health Department services. The process is structured so that each payor may be billed at different amounts for the same service (depending on the pre-determined fee schedule).

Payors include Medicare, Medicaid and Passport, each with its own unique policies and procedures. This complicates the process.

It is important to note that the Health Department is not responsible for these. While mitigating actions and controls can help minimize the adverse impact of these, the risk will exist until external parties address the issues. It is unreasonable to hold the Health Department entirely accountable for these issues.

2. Workflow Process – Internal

These issues are attributable to internal factors, which provide the Health Department the opportunity to control / address them. The internal control structure for these areas is weak. Opportunities were noted for improvements, but some issues are more systemic and ingrained and will take time to address. The major internal issues are as follows:

- **Data Entry Process**. Site personnel are responsible for recording patient services in the computer system. The quality of data entry at the sites may be impaired by the operating procedures, job duties, or staffing issues.
- **Financial Process**. Posting Health Department activity to the Metro financial system is complicated, and requires the use of the PSRS. The risks of inaccurate postings are increased because of this. There are also concerns regarding the safeguarding of funds from the sites to the bank.

The internal control rating is on page 5 of this report. The implementation of the recommendations in this report will help improve the internal control structure of the billing and collection activity.

Corrective Action Plan

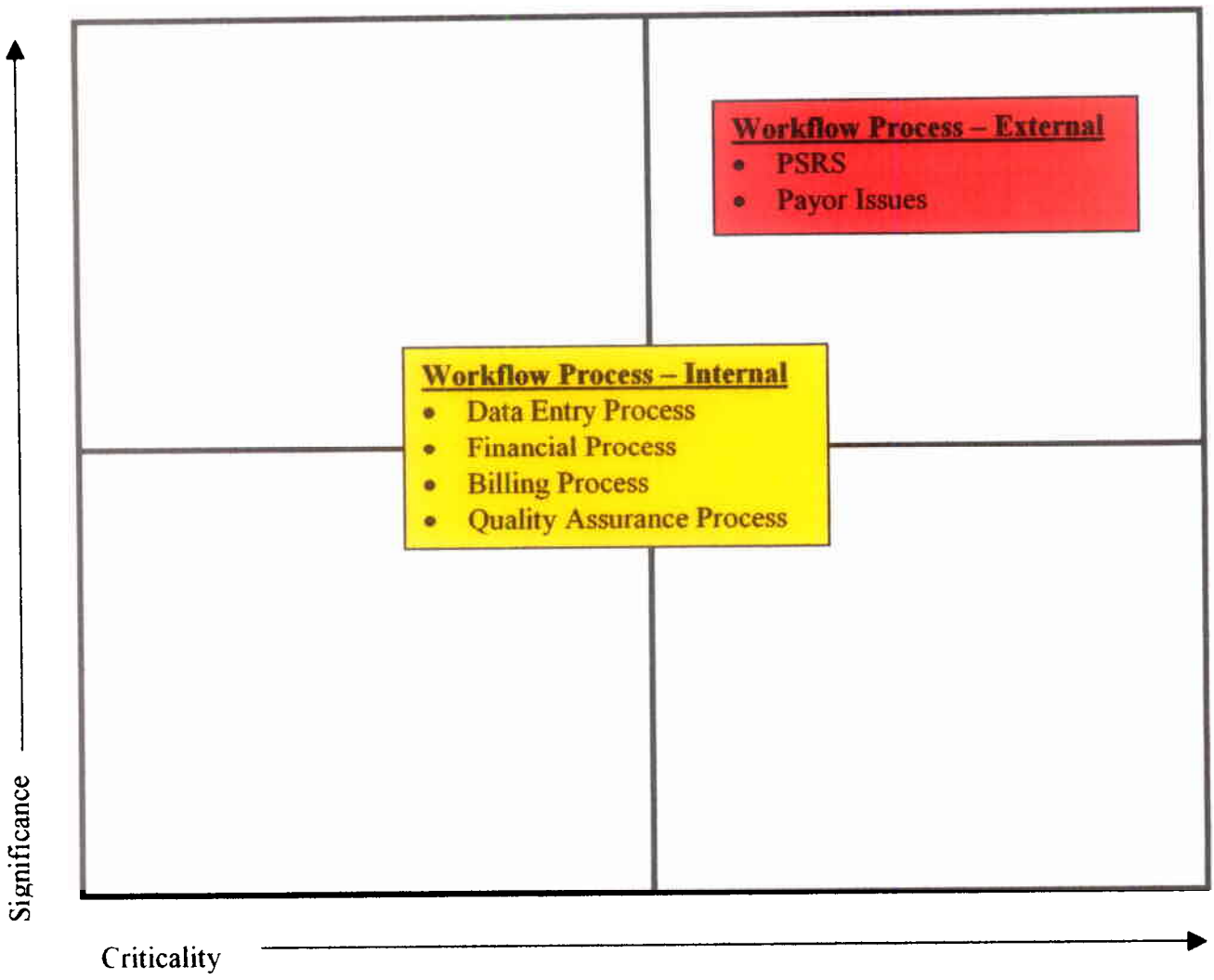
The Louisville Metro Health Department's corrective action plan demonstrates a commitment to addressing the issues that they can impact. It also recognizes the risk with the other issues. The corrective action plan is included in this report as responses in the Observations and Recommendations section. We will continue to assist the Health Department as necessary.

Sincerely,

Michael S. Norman, CIA
Chief Audit Executive

cc: Louisville Metro Council Audit Committee
Louisville Metro Council Members
Deputy Mayors
Secretary of the Cabinet for Health and Family Services
Director of the Health Department

Internal Control Rating



Legend

Criteria Issues	Satisfactory Not likely to impact operations.	Weak Impact on operations likely contained.	Inadequate Impact on operations likely widespread or compounding.
Controls	Effective.	Opportunity exists to improve effectiveness.	Do not exist or are not reliable.
Policy Compliance	Non-compliance issues are minor.	Non-compliance issues may be systemic.	Non-compliance issues are pervasive, significant, or have severe consequences.
Image	No, or low, level of risk.	Potential for damage.	Severe risk of damage.
Corrective Action	May be necessary.	Prompt.	Immediate.

Summary of Audit Results

Background

The mission of the Louisville Metro Health Department is to "protect, preserve and promote the health, environment, and well-being of the people of Louisville Metro, principally through health assessments, policy development, and assurance in an efficient, responsive, ethical, and customer friendly manner." Metro Health Department services are provided from the department's administrative headquarters, as well as, from 19 satellite and neighborhood place sites throughout the community.

The three major divisions of the Metro Health Department are Administrative, Population and Personal Health Services, and Environmental Health Services. The fiscal 2005 operating budget for the Metro Health Department is approximately $23.4 million; 35% of which comes from Metro Government, 42% from the Federal Government, 15% from State Government, and 8% from agency fees.

The Health Department uses the State's Patient Services Reporting System (PSRS) for billing, collection, and activity reporting. While services are billed to clients or medical coverage providers, the PSRS is also used to report information for which the State provides flat fees based on service levels and for grant funding.

This follow-up audit was requested by the Metro Council.

I. Current Audit Results

See Observations and Recommendations section of this report.

II. Prior Audit Issues

The Office of Internal Audit performed a review of the Health Department's billing and collection activity in 2003. The report was issued in December 2003. We would normally allow more time for implementing corrective actions before performing a follow-up review. However, the Metro Council requested that the follow-up review be performed at this time.

The Louisville Metro Health Department should be commended for the efforts made in addressing the prior audit issues. The Office of Internal Audit has been kept apprised of Health Department actions since July 2004. Health Department personnel have demonstrated a commitment to having a sound control structure for billing and collection activity. It is important to note that external factors limit the Health Department's ability in addressing all issues, especially in regards to the computer system (PSRS).

III. Statement of Auditing Standards

The audit was performed in accordance with the Standards for the Professional Practice of Internal Auditing issued by the Institute of Internal Auditors and with the Government Auditing Standards issued by the Comptroller General of the United States.

IV. Statement of Internal Control

A formal study of the internal control structure was conducted in order to obtain a sufficient understanding to support the final opinion.

V. Statement of Irregularities, Illegal Acts, and Other Noncompliance

The examination did not disclose any instances of irregularities, any indications of illegal acts, and nothing came to our attention during the examination that would indicate evidence of such. Any significant instances of noncompliance with laws and regulations are reported in the Observations and Recommendations section of this report.

VI. Views of Responsible Officials

An exit conference was held on May 26, 2005. Attending were Ken Kring, Evette Hudson, and Sue Wulf representing the Louisville Metro Health Department; Michael Norman and Jenni Schelling representing the Office of Internal Audit.

The views of Metro Health Department officials are included as responses in the Observations and Recommendations section of the report. The Metro Health Department has demonstrated a commitment to addressing the issues.

Methodology and Scope

The operating procedures for the billing and collection activities were reviewed through interviews with key personnel. The focus was the operational and fiscal procedures used to provide an accounting of activity (e.g., services delivered, patients served, billings sent, amounts collected), and the corrective actions implemented since the 2003 audit.

I. Prior Audit Issues

The major issues reviewed from the prior audit included the following:

- PSRS (State Computer system)
- Activity (Bill / Reimbursements / Account for All Services)
- Efficiency in Processes (Manual, Duplicative)
- Monitoring / Reconciliation
- Segregation of Duties
- Policies and Procedures
- Collection Agencies / Write-offs

Discussions were held with various authoritative resources. The purpose was to determine if the issues identified were unique to the Louisville Metro Health Department, or was more indicative of local health departments / service providers in general. The following were consulted:

- Family Health Center Portland – Louisville, KY (Interview)
- Health Care Consultant (Management Partners) – Louisville, KY (Interview)
- Lake Cumberland Regional Office – Somerset, KY (Interview & Site Visit)
- PSRS Administrator (Custom Data Processing) – Louisville, KY (Interview)
- Pulaski County Health Department – Somerset, KY (Interview & Site Visit)
- State Auditor of Public Accounts – Louisville, KY (Interview)
- State Cabinet for Human Resources – Frankfort, KY (Interview)

Site visits were performed for selected Louisville Metro Health Department locations to observe the work environment. The following sites were visited:

- Dixie Clinic
- Highview Clinic
- Jefferson County Lab
- Middletown Clinic
- Neighborhood Place – Bridges of Hope
- Neighborhood Place – East Louisville
- Neighborhood Place – Fairdale

- Newburg Clinic
- Specialty Clinic
- Tuberculosis Clinic

The Quality Assurance function was reviewed in interviews with key Health Department personnel. The purpose was to gain a general understanding of its performance, not to determine its effectiveness.

Health Department training sessions conducted for site personnel were attended. This was to observe the training approach, methodology, and site personnel receptiveness.

II. Review of Sample Data

The billing and collection process was tested by reviewing a sample of patient activity. The sample was intended to be representative of all Health Department sites and programs, excluding the billing and collection activities conducted by the Environmental Health Services Division or at the MORE clinic. Unless otherwise noted, the sample of data was from November 3-9, 2004. This period was chosen to provide enough time for the activity to have cycled through the entire process. Four distinct tests were performed, details are as follows.

(1) Billing and Collection for Patient Services

The purpose was to verify that services were being reported properly, billed, and payment activity accounted for accurately. This included programs / services billed for, and programs / services paid by grants. A total of sixty-eight patient encounters from nineteen Health Department sites were included in the review. A complete list of sites visited is listed in Appendix A. The test included reviewing patient encounter forms, medical records, billing fees, invoices, receipts, deposit documentation, bank records, and financial statements. This required obtaining data and reports from the Patient Services Reporting System, which is the computer system used for this activity.

(2) Missed Appointments

The purpose was to verify that patients scheduled for services did not show up for their appointment. The risk is that the patient may have been serviced, without the record being updated. This would understate the amount for billing, and may indicate improper handling of patient payments. A total of ten missed appointments were reviewed. The patient's medical record was verified to determine if services were provided on the date reviewed.

(3) Outstanding Patient Encounter Forms

The purpose was to verify that patients assigned an encounter for services, actually received services. The risk is that the patient may have been serviced, without the encounter form being recorded. This would understate the amount for billing, and may indicate improper handling of patient payments. A total of ten outstanding PEFs were reviewed. The patient's history, including medical records, was reviewed to determine if the encounter was entered and if service was actually provided.

(4) Lab Lead Services

The purpose of this test was to verify that lead-testing services provided for other Kentucky Counties are accounted for and billed properly. A supplemental spreadsheet system is used to administer this activity. A total of five lead billings were reviewed.

Observations and Recommendations

The Louisville Metro Health Department should be commended for the efforts made in addressing the prior audit issues. Health Department personnel have demonstrated a commitment to having a sound control structure for billing and collection activity. There are still issues that are impacting the effectiveness of the billing and collection activity. These issues are segregated into two distinct areas.

Workflow Process – External

These issues are attributable to external factors, which limits the ability of the Health Department to control / address them. The internal control structure for these areas is inadequate. These are more systemic and ingrained, and are severely impacting the billing and collection activity. The external issues are as follows:

1. Patient Services Reporting System (PSRS)
2. Payor Issues

It is important to note that the Health Department is not responsible for these. While mitigating actions and controls can help minimize the adverse impact of these, the risk will exist until external parties address the issues. It is unreasonable to hold the Health Department entirely accountable for these issues.

Workflow Process – Internal

These issues are attributable to internal factors, which provides the Health Department the opportunity to control / address them. The internal control structure for these areas is weak. Opportunities were noted for improvements, but some issues are more systemic and ingrained and will take time to address. The internal issues are as follows:

1. Data Entry Process
2. Financial Process
3. Billing Process
4. Quality Assurance Process

Details of the issues, along with recommendations, begin on the following page.

Workflow Process - External

Workflow process issues were identified. These issues are attributable to external factors, which limits the ability of the Health Department to control / address them. The internal control structure for these is inadequate, and is severely impacting the billing and collection activity. It is important to note that the Health Department is not responsible for these issues. While mitigating actions and controls can help minimize the adverse impact, the risk will exist until external parties address the issues. It is unreasonable to hold the Health Department entirely accountable for these issues.

Observation #1 – Patient Services Reporting System (PSRS)

Patient information, services rendered, and billing and collection activity are recorded in the Patient Services Reporting System (PSRS). This system is administered by a vendor, Custom Data Processing (CDP) on behalf of the State of Kentucky. It is used by the entire State, not just Louisville Metro. Issues noted with the PSRS and associated processes are adversely impacting the effectiveness of the Louisville Metro Health Department's billing and collection activity. These issues were noted in the prior audit. The primary issue is that the PSRS does not have the full functionality of an accounts receivable system. The following illustrate the major problems with the PSRS.

- The PSRS does not provide a payment trail for individual accounts. Therefore, payments for individual accounts can only be identified manually through PSRS reports and various source documents.

- Payments may be received but not recorded in the PSRS. This can occur when the site enters a service and a payment received, but then makes changes to the Patient Encounter Form (PEF) information recorded in the PSRS. This increases the risk that payments received at the site could be intentionally diverted without detection. The system requires that the revenue be reposted for it to be included in the daily activity report. In addition, deleted PEFs are not reflected on the PSRS report which records voided PEFs.

- There is no way to verify that daily deposits at a site agree to the monthly PSRS cash receipt report for the site. The PSRS report reflects all activity, including write-offs, adjustments for billing rate differences, etc. As a result, the totals cannot be efficiently reconciled to the site's deposit activity. Individuals could be verified by name, but this would be labor intensive and cumbersome, thus offsetting the value of the monitoring control.

- When a patient has an outstanding balance in PSRS, any payments received are automatically allocated to the balance, not necessarily to the activity that was actually being paid. PSRS automatically does this for all open balances. This impairs the reliability of the system in determining if payment for a particular service date has been collected.

- Credit balances are not reflected in patient history files in PSRS. This distorts the balances of accounts, and weakens the reliability of information from the system. There is also the risk that refunds are not identified and processed.

- The PSRS does not retain patients' accounts receivable data for lab services once payment is received. When the lab started using PSRS, the decision was made not to store the patients' accounts receivable. The reason given by CDP was that there would be additional costs associated with storage of the data.

These issues are adversely impacting the effectiveness of the control structure for the billing and collection activity.

Recommendations

It is critical to note that Louisville Metro Health Department does not administer the PSRS, so the ability to effect changes is limited. However, actions can be taken to attempt to minimize the adverse effects and address the issues noted. Specific recommendations include the following.

✓ The State should be consulted regarding the feasibility of changes to the system to address these issues. While Louisville Metro has the ability to request changes, there may be additional costs associated with making changes. Therefore, it is important to determine the feasibility of system changes, or if there is more cost effective methods to minimize the risks of the system. The result may be that it is most practical (cost effective) to recognize / accept the risk without system changes.

✓ The feasibility of replacing the PSRS, or supplementing it with another system, could be explored. However, this may be an expensive alternative, and could encompass new risks. For example, use of a supplemental system within the Health Department could result in double entry of data, additional accuracy issues, and impact on workloads. The benefits may not justify the additional costs.

✓ Health Department personnel should explore if additional functionality is available within the PSRS to address some of these issues. For example, there may be the ability to produce system reports detailing payments posted to prior balances, or accounts with credit balances. Manual action would still be necessary by the Health Department's billing office to review the reports and take any necessary action.

✓ At a minimum, a fundamental accounts receivable system should contain the following.

  - There should be a complete trail for all activity related to revenue.
  - Once a payment is posted in a system, it should not be able to be removed without supervisory action to "void" the transaction. The system should not require "re-

posting" of revenue received in cases where changes to the Patient Encounter Form are necessary.

- Systems should have the ability to reflect credit balances for accounts. This provides accurate accounting for activity, including proper balances. It also allows for automatic flagging of credit balances to allow determination of necessity of processing a refund.

✓ Without PSRS changes, effective compensating controls are critical. This includes Health Department personnel reviewing and reconciling existing work and system reports. Both site and billing office personnel should be involved in these tasks. Standardized training and documented procedures are required so that personnel understand their responsibilities. It is important to note that even with compensating controls, the risks of the PSRS not properly reflecting activity will not be totally mitigated.

✓ The cost of having the lab data stored should be evaluated in terms of the value / benefit added by doing so. It may be more beneficial to leave it as an unmitigated, but recognized, risk.

Health Department Response

The LMHD is committed to excellence, not only in the Billing Office, but also in all Health Department activities. As stated in the Mayor's strategic plan, the words "transform the Health Department" are closely followed by the Health Department's own strategic plan goal, "Develop a workplace that supports excellence, personal growth and satisfaction through training and communication and is a model of professionalism in all phases of operations." In addition, we are committed to a system that provides good internal controls, when and where possible, over all aspects of billing activity.

Throughout the following response, we have noted that we have worked on all issues identified through the prior year review by the Office of Internal Audit, and will continue to work on all issues identified by that office or others.

We have worked and will continue to work with the state patient billing system vendor, Custom Data Processing (CDP), concerning changes that might be made within the system that will add internal control features. For example, the Department has worked with CDP on creating a more user-friendly screen for the end users in the Lab. Listening to our concerns, CDP is currently working with state personnel to create new Accounts Receivable screens to track payments by date and by individual.

We realize that there are external factors beyond our control, such as using the state assigned Patient Services Reporting System (PSRS), which prevent us from making the changes needed to create an optimal data management and billing system. The current state system is used at local health departments in all of Kentucky's 120 counties for both data management and billing. While not ideal for patient billing, PSRS is the

system we are currently mandated to utilize. State personnel have explored the possibility of replacing PSRS and determined it would cost millions of dollars, as well as take more than 2 years, to put a new system in place statewide. We also have looked at the cost of replacing only the Louisville Metro patient billing system. The estimate is at least $1,000,000 in hardware and software requirements and possibly additional costs for dual data entry on an ongoing basis. In current financial times, neither scenario seems feasible.

We have placed and will continue to place as much emphasis as possible on creating compensating controls for internal control weaknesses identified in the audit. Currently, we are working with the state and the state's contracted computer vender, Custom Data Processing (CDP), to make changes to provide good internal controls, such as creating the payment-tracking screen. We understand the value of compensating controls and, as we have done over the past year, will continue to utilize the expertise of the Internal Audit Department to assist the Health Department in arriving at adequate compensating controls.

We have shifted work responsibilities of one Business Technician in the Billing Office to include review of all clinical reports to provide quality assurance over the data being entered into the system. A general review of problematic areas is being done on a daily basis.

Observation #2 – Payor Issues

A. Fee Schedules

Fees may be charged for services, depending on the type of service and the patient. There are several payors that may be billed for the services. This includes the Patient, Medicare, Medicaid, and Passport. The amounts billed vary based on the payor. Several issues were noted with the fee schedules.

- Multiple fee schedules complicate the billing process and increases the risk of inaccuracies. For the sample of sixty-eight service encounters reviewed, there were nine different fee / reimbursement schedules used. A matrix of Health Department services and funding sources is in Appendix B. This is included to illustrate the complexity of the operating environment.

- The State is responsible for maintaining / updating the various fees within the PSRS for the entire State except for the patient pay, which is the responsibility of the Louisville Metro Health Department. These schedules directly impact the accuracy of the Health Department's billing activity, even though the accountability / responsibility rest with the State.

- The Medicare reimbursement rate for flu shots for fiscal year 2005 was $17. However, PSRS charged $15 for these services. Health Department billing office

personnel were aware of this system problem and had worked with CDP to address it. After several months of discussions, it was determined that CDP had not processed the Medicare billing file. This will allow the rate to be corrected before the billing file is sent. The reason the system was charging at a different rate was not determined.

- There were five cases in which the total fees for the services recorded in the patient's PSRS accounts receivable file did not equal the appropriate fee / reimbursement schedule. The reason for the difference could not be determined.

- The HANDS reimbursement schedule is not current. It does not include the billing codes currently used, which were changed in October 2003. The State HANDS guide may have been revised since then, but the billing office did not have an updated copy.

B. Medicaid / Passport / Medicare

Medicaid is one of the State payors billed for Health Department services. Passport is the managed care component of Medicaid for Jefferson County. Medicare is one of the Federal payors billed for Health Department services. Several issues were noted regarding these entities.

- When Passport changes a reimbursement rate, there is no formal notification to CDP. As a result, processing continues at incorrect rates.

- The Medicaid fee schedules, including Passport and Passport Family Planning, may list two different fees for one service (CPT code). While one of the two fees was used for billing, Health Department billing office personnel could not explain why the particular fee was used and not the other fee.

- For patients covered by Medicaid / Passport, the PSRS accounts receivable balance is different from the fee / reimbursement schedule. The reason is that Medicaid reimburses a set fee for services, regardless of the actual amount of the service. While the Health Department bills Medicaid for the full amount of the service, the patient's receivable is recorded as the anticipated reimbursement rate. The goal is to have the reimbursement rate equal the receivable balance so that manual adjustments to the account are not necessary. While understandable, this weakens the reliability of the data within the PSRS. For example, there were a couple of processing mistakes noted that appear to be the result of the billing office having to manually adjust account balances to reflect the actual reimbursement amounts.

- Passport payments have to be manually posted to the patient's account; they do not automatically interface with the PSRS like other Medicaid payments. In order to determine the proper program to credit for the Passport revenue, each account / service has to be manually reviewed on the PSRS. This takes some time for the billing office staff to do, and may result in a delay in depositing checks. The delay

may be one week or longer. There is opportunity cost risk associated with this because revenue could be invested to earn interest for Louisville Metro, or used for other services. There is also the risk of physically losing the check. For the first six months of fiscal year 2005, approximately $250,000 was collected from Passport.

Health Department billing office personnel have worked with the business office and with Metro Finance to get the Passport checks deposited as soon as possible. This would entail the use of journal vouchers to post payments to the appropriate accounts. This approach has not been finalized. It is important to note that there are also risks with processing in this manner.

- The service code (CPT) used for Lead Investigation services is not Health Insurance Portability and Accountability Act (HIPAA) compliant, so Medicaid will not reimburse the Health Department for these services. The State has yet to provide the proper code to use. This has been an outstanding issue for approximately 1½ years.

- CDP switched to a HIPAA compliant file layout within the PSRS for family planning services. The company that processes these claims on behalf of Passport uses a clearinghouse that cannot process the file layout. This has delayed reimbursements to the Health Department and has been an outstanding issue for several months.

- Medicare billings were delayed while the Health Department obtained a proper Medicare billing number.

- The Medicaid billings for one site were delayed while application for the proper Medicaid Provider number was made. The application was made for the site's Medicaid provider number, but it was rejected. The Health Department was told that a "Certificate of Need" was required, but no one could explain what that was. Reapplication was made in late February / early March 2005, but a response had not been received as of April 2005.

C. Lab Lead Services

The Louisville Metro Health Department Lab provides lead analysis services to other Kentucky Counties and providers. Billing for this activity is either to Medicaid via the PSRS, or directly to the County. Issues were noted with this activity.

- Activity billed to the other Counties cannot be administered by the Health Department's billing office through the PSRS. As a result, spreadsheets are used to track the activity. While the need for developing the spreadsheets is understandable, there are risks with this approach, especially since it is not a true accounts receivable system. For example, there is not a cumulative total of outstanding invoices available. Each County has its own spreadsheet. Calculating a cumulative total would require going through each County's spreadsheet.

It should be noted that the billing office uses Quickbooks for contract billings. While Quickbooks may provide a better accounts receivable system than spreadsheets, it requires training and some expertise to use, and may be more cumbersome than the current approach.

- The Health Department Lab enters only the results of the lead analysis within the PSRS. All patient demographics and service information is entered by the County seeing the patient. Thus, Louisville Metro has no control over the accuracy or integrity of this data, but is impacted by it. If the County enters information incorrectly, or omits it, extra work is created for the billing office (through research, tracking, additional billing, etc.). This may be taking human resources away from other billing tasks.

- The fee that Louisville Metro charges the Counties is the old Preventive Medicaid reimbursement rate of $16.72 (Passport's rate is $15.30). However, Medicaid changed the reimbursement amount to a tiered structure, so the amount varies depending on the provider type. The current Medicaid rate is approximately $10.40.

  Louisville Metro Health Department personnel indicated that a request has been made to the State asking for permission to change the billing fee to the current Medicaid rate. The reason for requesting the change was to attempt to keep Counties from going to other labs where the cost for these services would be less. The lab did a cost analysis that shows that actual costs, not including overhead, would be covered by this Medicaid rate, so the Health Department would not lose money on services billed to Counties. The status of this request is unknown. The unresolved issue has the potential to negatively impact lab services if Counties choose to use other providers.

Recommendations

It is important to note that Louisville Metro Health Department's ability to address these issues is limited. However, actions can be taken to attempt to minimize the adverse effects of the issues noted. Specific recommendations include the following.

- ✓ Ideally, one fee schedule should be used and all parties billed at the same rate, with appropriate adjustments made to patient accounts as payments are received. However, constraints (e.g., system, funding requirements, financial and human resources) may prohibit changes to the current process. If so, the current method of attempting to have the PSRS automatically establish the accounts receivable at the applicable reimbursement rate may be the most practical approach.

- ✓ While the arrangement of the State maintaining the PSRS, instead of Louisville Metro, is not ideal, it may be the most sensible at this time. It appears a change to a different system would be costly. Therefore, Louisville Metro should attempt to work with the State to formalize a change notification process. This would allow Louisville Metro to review State changes to ensure there are not unintended results.

- ✓ CDP should be requested to provide formal training / documentation for the fee schedules within the system. This includes fees / parameters "hard coded" into the system. This documentation is necessary to provide some assurance to Louisville Metro that processing is occurring as intended.

- ✓ Medicare invoices for flu shots for fiscal year 2005 should be transmitted as soon as the rate within the file is changed to the correct amount.

- ✓ The Health Department's HANDS program manager should determine if an updated fee schedule is available. If so, it should be provided to the billing office. In the future, Health Department program managers should be required to notify the billing office whenever programmatic changes are made. This will help ensure the billing office has the most current program guide / requirements and is billing at the appropriate rates.

- ✓ While Louisville Metro Health Department has no control over Passport, attempts should be made to formalize communication whenever changes occur, especially related to reimbursement rates. This should include notification to CDP so that processing delays / additional work are minimized.

- ✓ Ideally, Passport payments would automatically post to the patient account in the PSRS. Discussions have occurred about this issue, but a commitment for doing so has not been made. Louisville Metro Health Department should continue working with Passport to try to get this in place. In the interim, the Health Department should continue working, with the assistance of Metro Finance, to get payments deposited as quickly as possible.

- ✓ Efforts should continue to work with the State to resolve the Medicaid issues. This includes obtaining the necessary provider numbers, as well as HIPAA compliant CPT codes. It may be beneficial to assign the responsibility for these tasks to one individual within the Metro Health Department. This individual could work with the State not only on Medicaid issues such as those noted, but also other issues that impact funding. This person should be empowered to make necessary changes and communicate to the Metro Health Department.

- ✓ Delays in billing should be avoided whenever possible. Some circumstances, such as delays at the Federal level for the Medicare billing number, are out of the control of the Health Department. The effects of anticipated delays may be alleviated through planning and temporary service delivery changes.

- ✓ The use of spreadsheets instead of an accounts receivable system should be evaluated. The value of the missing functionalities of spreadsheets may not be enough to justify the implementation of a supplemental accounts receivable tool. However, since Quickbooks is already used for some billing activity, it may be feasible to implement its use for this activity. This should not be done without proper training and support.

- ✓ The value of the Lead analysis services should be reviewed. A cost / benefit analysis should be performed that considers not only the revenue sources and amounts, but the costs of providing the services, including overhead for items such as billing activity. It may be more cost effective to discontinue this service for all other Kentucky Counties, for Jefferson County, or for both.

- ✓ A decision regarding the rate charged for non-Medicaid patients should be made. If this requires State approval, it should be obtained. It may be possible to increase revenue, through additional cases, by decreasing the rate charged.

Health Department Response

LMHD has one fee schedule, which is approved by the Board of Health on an annual basis. We will work with CDP and the State to try to minimize the number of fee adjustments used. As an example, we are working with CDP to create a "contractual allowance" account for Medicare, which would allow the automatic posting of a standard $20 charge to a patient account for a flu shot. Following that, the system would automatically post a $3 contractual allowance reduction, leaving a $17 balance. When payment is received, the payment would be posted to the account. Account activity would be reflected as follows:

Flu Shot	20
Contractual Allowance	-3
Third Party Balance	17
Payment	-17
Remaining balance	0

A meeting has been scheduled with CDP and state personnel on June 20, 2005 to discuss fee schedules and related issues.

Medicare flu shot claims have been transmitted, with approximately $140,000 received to date. Additional receipts are anticipated.

We have been working with Passport and CDP since 1997 to have Passport payments posted electronically. One of the local health departments in the Passport Region is currently working as a test site on electronic posting. CDP and that health department have identified several problems they are working to correct. Once corrected, electronic payment posting will be rolled out to the rest of the region.

The Billing Supervisor has been assigned the overall responsibility of communicating with all parties concerning the billing system and or billing issues, and is empowered to make necessary changes within the system.

After Billing Office personnel receive additional training on Quickbooks, the Department will determine the feasibility of utilizing this software for billing non-

Medicaid Lead Laboratory Tests performed for other local health departments in Kentucky. The Department believes there is an overall cost benefit to the LMHD Laboratory of analyzing Lead Laboratory Tests for other local health departments in Kentucky. State personnel have advised that, beginning FY 06, Preventive Medicaid will have one reimbursement rate for lead screenings instead of the three-tiered rates, based on provider types, currently used. This should simplify our billing procedure.

All other recommendations listed in this section have either been addressed as suggested by Internal Audit, or will be in the near future.

Workflow Process – Internal

Workflow process issues were identified. These are attributable to internal factors, which provide the Health Department the ability to control / address them. The internal control structure for these is weak, and is impacting the effectiveness of the billing and collection activity. While the Health Department is accountable for these issues, some items are systemic in nature and cannot be easily or quickly addressed.

Observation #1 - Data Entry Process

Accurate and complete data is an integral component to an effective billing system. Services delivered are recorded in the Patient Services Reporting System (PSRS) by Health Department site personnel. The quality of data entry at the Health Department sites may be impaired by the operating procedures, job duties, or staffing issues. In addition, some data entry errors will occur simply because of the human element involved.

Inaccuracies in data entry result in the billing office dedicating human resources to investigating problems, and attempting to obtain accurate information. This has a detrimental impact on the efficiency of the billing and collection activity, and can result in unprocessed reimbursement claims, and weakened reliability of the PSRS data. It should be noted that the billing office tries to perform some quality assurance reviews on the data keyed (by reviewing PSRS reports). Folders are maintained for each site with possible problems, and corrective action / instructions provided by the billing office as needed. However, it is difficult to identify some types of data entry errors since the source documents are kept at the sites.

A. Data Entry Test Results

A sample of transactions was reviewed. The purpose was to determine accuracy of data recorded in the PSRS. The sample was comprised of sixty-eight transactions from nineteen Health Department sites. The transactions were reported in the PSRS during November 2004.

I. PEF / Lab Requisitions

Information recorded on the Patient Encounter Forms (PEFs) or Lab Requisitions was compared to data in the PSRS. The State Cabinet for Health and Family Services uses a 92% accuracy rate guideline. The results are as follows.

- PEF / Lab Requisition entered correctly – 46 of 68 (68%)
  - ➢ The data verified was the CPT, Provider, and ICD9 codes:
    - CPT Codes entered correctly – 246 of 277 (89%)

- Provider Codes entered correctly – 104 of 126 (83%)
- ICD9 Codes entered correctly – 134 of 154 (87%)

The detailed results, by site, are in Appendix C. This is noted to illustrate that some sites meet or exceed the State guideline, but it is important to note that the sample sizes at each site may not be statistically significant to allow extrapolation to the entire site population.

- Some mistakes are going to occur within any system involving manual data entry tasks. Examples of these are noted in the following.
  - The nature of some errors may be indicative of a lack of understanding of the process, system, or functions. Examples include not properly voiding a PEF in the PSRS and using fictitious names to block scheduling times when the provider is not on site.
  - Other mistakes appeared to have been the result of carelessness or oversight. This includes actions such as entering the same requisition twice under two different PEF numbers, entering two different PEFs for the same services, and switching PEF labels on requisitions.

II. Timeliness

Timeliness of entry was reviewed. The criterion was within fourteen days of the service date.

- Data entered timely – 53 of 68 (78%)

III. Medical Records

The Patient's Medical Record was reviewed to verify that services were provided on the appropriate date (appropriateness / level of service was not reviewed).

- PEF agreed to Medical Record – 50 of 53 (94%)
  - Two of the three were missing the document (CD 26 card) used for flu shots only. The other involved a patient with two medical record numbers in the PSRS, but only one physical record. It should have been combined into one.

B. Filing Issues

Filing issues were noted in regards to filing both of medical records and Patient Encounter Forms (PEFs).

- Approximately three hundred Medical Records were on a cart at one site. They had not been filed onto the shelves, and were not in any particular order.

- Several cases were noted involving the filing of PEFs at the sites. Examples of these include the following.
  - ➢ One case in which the PEFs were not filed at the Health Department site. They were in boxes stored in a non-Health Department area of the facility.
  - ➢ Three cases in which the PEFs were stored in boxes in no particular order. Billing office personnel located the PEFs in the sample by physically going through the boxes at the time of the site visit, or site personnel subsequently located the PEF after the site visit.
  - ➢ One case in which the PEFs were not filed in an orderly manner at the site. They were stored in order by month, but not in date order. Billing office personnel were able to locate the PEFs in the sample by physically going through the files.

- There were two sites (HANDS locations) in which patient documents are filed by the name of the site counselor who provided the service, then by month. There is limited space provided at these Health Department sites to store medical files and the files were retrievable with assistance from site personnel.

These filing issues increase the risk of non-compliance with State and funding requirements, including provisions of HIPAA.

C. Documentation - Lab Requisition Forms

The Lab requisitions do not note the CPT, Provider, or ICD9 codes. The Lab Data Entry Clerks are expected to know the appropriate codes to enter for each Lab Requisition. While this expectation is reasonable for the provider code since it is the same for all, it may not be reasonable for the CPT and ICD9 codes. This may increase the risk of data entry errors. There may be a Lab manual available that includes these codes, but it is uncertain if they are up-to-date or used by the Data Entry Clerks.

Recommendations

It is important to note that the major issues identified are systemic, and thus not easily or quickly correctable. However, actions can be taken to attempt to minimize the adverse effects of these systemic issues. Other items noted can be addressed more easily and timely. Specific recommendations include the following.

- ✓ The workflow at the sites could be evaluated to determine if there is a better way to administer activity. This includes the way data is captured and entered; and the job responsibilities, classifications, and compensations for those performing data entry duties. This could also include centralizing / regionalizing the data entry function.

There are pros and cons to this approach that should be considered. The goal should be an efficient, effective system that provides accountability and high standards for accuracy. However, the limitations of the PSRS have the potential to impact the effectiveness of workflow changes, and must be considered when evaluating re-engineering opportunities.

- ✓ The Metro Department of Human Resources should be contacted regarding the job classifications of personnel responsible for entering data. Job audits may be needed to determine if the appropriate skill sets are required for the position. It may be that the current classifications are improper given the level of complexity and responsibility involved. It is very difficult to hold personnel accountable if they are not qualified to do the job. Collective bargaining agreements may impact the timing of this, but it should be pursued when feasible.

- ✓ Appropriate supervisory personnel at the sites should perform quality assurance functions by periodically reviewing data entered and verifying to source records.

- ✓ Training should be routinely provided for data entry personnel. This includes refresher training in addition to changes and new processes. It may be possible to use web-based approaches to expedite this training. State resources could be used when appropriate for specific training issues.

- ✓ Since the PSRS is not controlled by the Health Department, there may be limited opportunity to impact its functionality. Changes such as additional system edits designed to strengthen data integrity, or methods to decrease the amount of data entered, such as bar coding of services, could be considered. However, these types of changes may be too expensive to be feasible.

- ✓ Activity should be continuously monitored to help ensure data is being recorded accurately. Once properly trained, site personnel should be held accountable for data entry accuracy.

- ✓ The importance of the Quality Assurance (QA) function should be prioritized. Periodic checks of data, by independent sources, are an integral component of a strong QA function. Appropriate personnel should be responsible for addressing issues identified in QA reviews. This may include requesting additional training in problem areas.

- ✓ Filing of patient's medical records should be assigned to specific site personnel. Coordinators should ensure this task is being performed timely. Compliance with all regulations and requirements, including HIPAA, is critical. Internal Quality Assurance reviews should encompass verification of proper filing of medical records.

- ✓ Site personnel should be provided instructions regarding blocking of time. Fictitious data should not be used. Once the procedure has been explained to site personnel, they should be accountable for adhering to it.

Health Department Response

LMHD understands the importance of entering accurate data into PSRS. A pilot project was initiated at the Newburg clinic to look at this issue, with project steps as follows:

1. Explained desired results of the project — additional cash collections, better data accuracy, and improved productivity — to all staff. .
2. Obtained staff input in an attempt to accomplish better results, and implemented the plan based on staff suggestions.
3. Created a resource manual for the clinic, showing data elements, how to key data in the system, how data should be obtained, etc.
4. Identified one person to be the primary party for data entry.
5. Provided additional training to that identified individual.
6. Monitored data daily and shared results with clinic personnel.
7. Established benchmarks and gave to staff.

Results of the pilot project were promising, and included improving data accuracy, productivity and collections.

In addition, we have discussed re-classifying the Community Health Clerk position at each location. The new position would include primary responsibility for accurate data entry and collection, as well as overall financial oversight for the location. Salaries might have to be adjusted to accommodate these changes, but LMHD believes improved quality of data, data entry, and collections would more than make up for any funds expended on project implementation across the Department. Such a change would necessitate clinical supervisors becoming more involved with billing activities.

The Department has assumed more control over internal workflow processes and will continue to place added emphasis on the areas that provide cost benefits. For example, in the HANDS Program, which is currently producing annual revenues estimated at $1,200,000 in service fees, we have shifted personnel resources from another program to allow a staff member to perform quality assurance over the data entered into the system for the HANDS Program. The result has been that the Department is now collecting at a higher rate and re-billing at a lesser rate than in prior years.

Another plan for the future is to shift the supervision of Lab data entry clerks under the billing supervisor, thus assuring timeliness of data entry, as well as accuracy of data going into the lab portion of the billing system.

A Continuous Quality Improvement process has been implemented, which requires site supervisory staff to perform monthly data accuracy checks. These checks are sent to a central source and reviewed for recurring issues. Training will be designed to address repeated errors or inaccurate data entry.

Beginning FY 06, a *Weekly Reminder* email alert will be sent to all PSRS users. This email alert will be used to notify staff of changes and updates, and will serve as a training mechanism for users on issues identified through quality assurance.

To address filing of Medical Records, during a June 1, 2005 training session we instructed all clinical personnel that filing should be done on a daily basis by close of business.

The blocking of schedules has been discussed with key personnel. Fictitious names will not be used in the future to accomplish that task.

Observation #2 - Financial Process

A. Metro Financial Statements (Program Centers)

Payments received at the Health Department sites, including the billing office, are deposited into a Metro bank account. The money is transferred into a clearing account and booked into Metro's financial system. The Health Department business office prepares journal vouchers to transfer the funds into the appropriate program financial centers. Several issues were noted with this process.

- In order for the business office to know the amounts to record in each program financial center, billing office personnel have to provide information from the PSRS. Billing office personnel have to manually review each site's PSRS cash receipt reports to determine the appropriate amount to record.

- In December 2004, the PSRS administrator (CDP) provided information to the billing office regarding the PSRS reports. It was determined that incorrect amounts were being reported, i.e., that all activity, including items other than cash receipts (e.g. write-offs) was included in the amount reported to the business office.

- Prior to September 2004, the business office weighted the totals for each program based on the monthly receipts. This was necessary because the totals did not agree to the month's receipts. The weighted amounts were then recorded in each program's center on the Metro financial system. After learning of the reporting issues, it does appear that attempts were made to correct the amounts that had been posted to the program financial centers (for September 2004 through December 2004) using this weighting approach.

- The process was changed so that the billing office reports only the code for cash receipts. However, it appears that the amount being reported may still be incorrect. It appears to be the total of the debits and the credits added together, not netted. If the debits are refunds for payments that have already been recorded in Metro's financial system, then the amount may be correct. However, if the debits include write-offs or adjustments on accounts that were not recorded in Metro's financial system, the amount may be incorrect. A final determination has not been made.

As a result, the reliability of the financial system data is weakened.

B. Security of Funds

The various Health Department sites collect revenue from patients. An armored car service was used to pick up the deposits from the sites and deliver to the bank / Metro Treasury. The contract with the armored car service expired. A contract already existed with a courier service, so the fund deposit task was assigned to this courier service. The

courier service picks up the deposits at the various Health Department sites and delivers the deposits to the bank on the same day.

- While this may be more cost effective in the short-term, it creates a larger exposure risk for Metro. Although the courier service may use certain runners for these deliveries, in case of a loss, they only guarantee up to $200 cash and reconstruction costs of lost checks. Some Health Department sites may collect as much as $1,400 each day in cash.

- It appears that the courier service does not take any special precautions for securing the money bags picked up from the sites. It was observed that the bags were in the plastic tub used for carrying other correspondence and items, and no special safeguards were taken.

It should be noted that this issue impacts all Metro Departments, not just the Health Department. It has been directed to the Metro Finance Department (Accounting Division, and Risk Management Division) for assistance. However, the Health Department is ultimately accountable for ensuring the safeguarding of funds collected at its sites.

C. Timeliness

I. Bank Deposits

- There was one case in which the bank deposit was actually made nine business days after the date recorded on the deposit ticket. The reason the site delayed processing the deposit is unknown.

- The criteria used for verifying timeliness of deposits is within five business days of receipt of payment. However, there is no way to determine how long a check is actually in the billing office before being processed for deposit. A "date received" stamp is used, but this does not indicate the actual date received by the Health Department. The billing office stamps the date the check is ready to be processed for deposit, which is after the appropriate financial coding has been determined.

  Due to this, the check date was used to test deposit timeliness, and the criterion was changed to ten days to allow for mail processing time. There were three cases in which the deposit was not within ten days of the check / payment date. This ranged from twelve days to nineteen days.

Cash management principles dictate that payments / revenue be deposited timely.

II. Metro Financial System

- For twelve of the seventeen deposit transactions reviewed, monthly program totals were not posted to the appropriate financial program centers in a timely manner. Timeliness is defined as within the same effective month as the clearing account posting date (to match to the appropriate period). The delays included October and November activity not being posted until January.

III. PSRS

- Only activity that has been posted to the PSRS can be transferred from the clearing account to the specific program centers on Metro's financial system. Therefore, if the billing office gets behind on posting payment activity, the revenue will be held in the clearing account until the activity is posted. This increases the risk of posting mistakes and errors.

- There were several cases in which the payment information was not posted to the PSRS in a timely manner. Timeliness is defined as being within ten business days from the date the deposit was processed. The delay ranged from twenty-three days to thirty-two days. Two of the cases involved flu shots. In one case, the billing office processed the check for deposit on March 3, 2005. As of March 31, 2005, the payment had not been posted to the PSRS.

D. Reporting to State for Grant Reimbursements

Health Department business office personnel manually convert Metro financial system reports of program activity into a report in State required format. This is done each month for grant reimbursements. For example, the WIC report for the State must be specific to each section of the program (e.g. administrative, education, client services). This manual process increases the risk of errors and mistakes in reporting, and could impact the business office's efficiency and effectiveness.

Recommendations

It is important to note that some of the issues identified require involvement of entities outside of the Health Department. Therefore, these may not be easily or quickly correctable. Specific recommendations include the following.

✓ The full functionality of the PSRS should be explored to determine if the reporting capability could provide the information needed for the business office without manual intervention by the billing office. The feasibility of having PSRS produce one report with the required information should be a goal.

- ✓ The PSRS Administrator (CDP) should be requested to provide additional training in using / interpreting the system reports. The training should include documentation that explains the reports.

- ✓ Billing office personnel should try to post activity to the PSRS in as timely a manner as possible. One goal could be getting all activity posted within the same month as received, with a cut-off date towards the end of the month.

- ✓ Timely posting of complete activity to financial statements is essential. This helps ensure the financial statements are accurate and complete. It also helps provide a mechanism for reconciling the clearing account to the program accounts.

- ✓ Metro Finance, including the Risk Management Division, should be requested to help address the issue of safeguarding of funds.
  - Many Metro sites besides the Health Department collect revenue. Therefore, there should be an entity-wide policy that ensures uniformity in the safeguarding / deposit procedures. This may include the use of one armored car / courier service for the entire enterprise.
  - The cost / benefit of using an armored car service as opposed to risk exposure of employees / couriers should be considered in developing the Metro policy.
  - Delivery of deposits should be handled by a bonded courier service that would ensure security of funds, and replacement of funds in the case of a loss. The security of the funds should warrant special handling accommodations.
  - The policy should explicitly outline Metro Government employees' personal liability / responsibility if their job duties require taking deposits to the bank.
  - The policy should include procedures for documenting the chain of custody for transferring deposit funds from one individual to another, including an armored car service. This helps to ensure accountability and safeguarding of assets.

- ✓ In the interim, appropriate Health Department personnel should discuss this situation with the courier service, and request that the daily limit of guaranteed funds be increased to $1,500 for the methadone clinic location. It may be feasible to leave the guarantee at $200 for the other sites if cash is not routinely collected. In addition, safeguards for securing the deposit bags should be required, i.e., the bags should not be visible and placed with other correspondence. This will help mitigate some of the physical risk of transporting the funds in this manner.

- ✓ Revenue / payments should be deposited timely. A recommended policy is within five business days, or at a pre-determined threshold. The Health Department should determine the thresholds, considering that it may be lower for some sites than others. Sites receiving significant amounts of cash may warrant lower thresholds.

- ✓ The necessity of making timely deposits should be stressed to all site personnel. This should be monitored so that sites with consistent delays can be identified and corrective action taken.

- ✓ Program activity should be posted to the financial system in a timely manner. At this time, there is not a Metro policy defining timeliness. It is suggested that the goal of posting within the same effective month as the posting to the clearing account be used. Requiring more frequent postings, such as weekly, could be burdensome on Health Department personnel, and may not provide enough benefit to outweigh the additional administrative tasks.

- ✓ The necessity for timeliness in billing and collecting activity should be understood by all billing office staff. This includes documenting the dates activity occurred, and depositing funds as soon as possible.

- ✓ The use of a date stamp to indicate when a payment is received is recommended. This provides documentation to help determine where delays may occur in the deposit process.

- ✓ The Metro financial system's functionalities should be explored to determine if there is a more efficient process of obtaining the needed data in the State required format for grant reimbursement reporting. Metro financial system administrators should be consulted regarding the feasibility of developing reports that could be used for State reporting purposes.

Health Department Response

The Billing Office was providing spreadsheets to the Business Office for posting, allowing for possible errors during the process of transferring data from an original computer report to the spreadsheet. In turn, these erroneous figures were posted to the accounting system. The Billing Office is now providing the original computer printouts to the Business Office for posting.

We have requested that our current courier service increase the limit of guarantee from $200 cash to $1,500 cash daily, and are awaiting their response. It should be noted that the request was made, verbally, before the service began. In addition, the risks of moving to the courier, from the previous armored car service, were evaluated. The Department decided at the time, the $10,000 a year in savings from paying the armored car company was worth the risks of using regular courier services, as most clinical sites do not have large sums of cash deposits daily. We have not had a loss since initiating the courier service. In conclusion, the Health Department is willing to follow any Metro policies derived as to how to pick up money and make deposits.

The Health Department developed a cash collection policy for field and environmental activities, which was reviewed by the Office of Internal Audit. Current

policy is that deposits are either made daily, or when deposits total more than $1,000. Circumstances occur, from time to time, which prohibit the policy from being followed, but are rare. When the policy cannot be followed there are certain security measures in place to assure the security of dollars collected.

All other comments within this section have either now been addressed / corrected or will be in the near future.

Observation #3 – Billing Process

A. Completeness

Issues were noted regarding the billing / reimbursement for all services provided.

- Services provided to patients while incarcerated at Metro Corrections or the Metro Youth Detention Center are not billed to the patient, Metro Corrections, or the Youth Center. Billing office personnel were instructed not to bill for these services. However, an accounts receivable is established in the PSRS for the services. The account is not adjusted, so the status remains open.

- The Health Department does not bill Medicare / Medicaid for some services (tuberculosis, specialty) provided via contract with the University of Louisville (U of L). The reason Medicare and Medicaid are not billed for these services are that U of L is not sure if the positions are already included in their cost basis. If they are, then billing Medicare / Medicaid would result in double billing. In order to mitigate this risk, the prior contract specified that these services would not be billed. However, for the fiscal year 2005 contract, the language regarding this is not included. Health Department officials feel the intent did not change, and are not sure why the language was not included. As a result, the Health Department has not billed for these services for fiscal year 2005.

- The Health Department bills private insurance companies for patients served. It should be noted that this was not consistently performed at the time of the prior review, so the billing office should be commended for implementing this procedure. However, the procedure and guidelines are still evolving, and thus not yet finalized. Issues such as re-billing denied claims and billing the patient when insurance information is incomplete are still being worked out.

B. Timeliness

Issues were noted regarding the timeliness of processing activity.

Flu Shots

Flu shot vaccination services may not be keyed into the PSRS in a timely manner. This applies to vaccinations given outside of regular Health Department sites. Any funds collected from patients at the time of the vaccination are deposited. The keying delays are primarily due to the volume of transactions and lack of staff available to dedicate to this task. The data keyed is necessary for recording patient payments, reimbursement from payors, and reporting purposes.

Health Department staff performs this duty as time allows, and tries to key in chronological order. Priority may be given to contract billings, then Passport, then

Medicare. The Health Department has 120 days from the date of service to make a claim for payment from Passport, one year for Medicare claims.

Since the payors (e.g., contract, Medicare, Passport) account for approximately 50% of the activity, keying delays may result in revenue due the Health Department not being requested timely. As a result, other funding sources (e.g., general fund) may have to be used to cover the cost of these services. For perspective, in 2004 approximately $95,000 was received just from Medicare for flu shot services.

HANDS

There were two of five HANDS cases in which Medicaid was not billed in the next billing cycle, but was billed in the cycle following that. The reason for the delay was not determined.

C. Supporting Documentation

Issues were noted regarding supporting documentation used for billing purposes.

- The Planned Parenthood contract expired June 30, 2003. There may have been a contract in effect during the period reviewed, but the billing office did not have a copy. This could result in incorrect amounts being billed. In addition, the contract stated the fee for the gonorrhea and chlamydia laboratory services, but not the corresponding CPT codes. The fees charged did agree to the contract.

- There were several cases noted in which the CPT code was not on the Health Department Medical Fee Schedule, or the fee noted was incorrect. These were not cases in which the CPT code was added / changed since the Fee Schedule was last updated. This weakens the reliability of the billing activity since there is no support for the fee charged.

Recommendations

It is important to note that some of the issues identified require involvement of entities outside of the Health Department. Therefore, these may not be easily or quickly correctable. Specific recommendations include the following.

✓ Billing / reimbursement activity should encompass all services provided, at least to the fullest allowable extent.

  – The rationale for not billing Metro Corrections or the Youth Detention Center for services may need to be reviewed, especially since a prior Health Department administration made this decision.

- If the decision is made not to bill Metro Corrections or the Youth Center, the patient's account receivable balance should be flagged for immediate write-off.
- The Health Department should consult with University of Louisville officials to determine if the intent is not to bill for the services, even though the language is not in the current contract. If that is not the intent, then efforts should be made to bill for all services delivered under this contract.
- The Health Department should evaluate the cost / benefit of this contractual relationship with the University of Louisville. U of L should be strongly encouraged to determine if these activities are already in their Medicare cost basis, which would make them ineligible for billing by the Health Department.
- The Health Department should do a cost / benefit analysis to determine if it is more beneficial to make arrangements for service providers through other methods (e.g., contracts with other providers, additional staff) than U of L. The focus should be recovering money from other sources whenever possible without jeopardizing the quality of services provided.
- If the current arrangement is determined to be the best approach for these services, the contract should be specific as to the billing of Medicare / Medicaid for the services.

✓ Policies and procedures for billing private insurance should be finalized, formally documented, and disseminated to appropriate personnel. The policies and procedures should be comprehensive enough to allow day-to-day processing of activity, while recognizing that it may not be possible to address all situations.

✓ Site personnel should be accountable for obtaining complete private insurance information. Site Coordinators and Managers should be notified whenever complete information is not properly obtained. It may be beneficial to remind site personnel of the critical role they play in allowing comprehensive billing activity to occur.

✓ The feasibility of getting flu shot services keyed into the PSRS in a timely fashion should be explored. Options may include:

- Stratifying the service encounter records so those with revenue due from payor sources are identified and given keying priority.
- Adding temporary staff or temporarily reassigning duties so that service encounters can be keyed timely.
- Using technology, such as bar codes, to expedite entry of these encounters in the system.

✓ Health Department Program Managers should be required to notify the billing office whenever programmatic changes are made. This will help ensure the billing office has the most current program guide / requirements and is billing at the appropriate rates. This includes contracts as well as grant agreements.

- ✓ The feasibility of more frequent updates of the Health Department Medical Fee Schedule should be reviewed. Assigning the responsibility of maintaining the schedule to one individual may help. It may be possible to post the schedule to the intranet so that the most current version is always available for all Health Department personnel.

Health Department Response

Under prior Administration, a decision was made not to bill Corrections or the Youth Detention Center for certain services rendered. There was no memorandum of understanding on file, so the current staff are not sure of the reasoning behind this previous decision. Currently, we do bill Corrections for drug screens. LMHD will explore the possibility of billing Corrections for TB services to inmates, but will continue to provide other testing paid for by specific grants. We also will explore the possibility of billing the Youth Center for services to their population.

If the decision is made not to bill inter-departmental accounts, the Department will work with CDP in establishing methods of writing off the accounts.

The language regarding not billing for physician fellow services will be added back into the University of Louisville contract that covers this collaboration. The long-standing partnership between the University of Louisville and the LMHD should be a point of consideration in cost benefit analysis concerning physician contracts and other contracts. The collaboration between the Health Department and the University to enhance the public health workforce and public health services is beneficial to the community as a whole, but is difficult to quantify monetarily. According to state and federal mandates to Local Health Departments, one of LMHD's core functions is to either directly provide public health services or to assure they are provided. The University has assisted the department in achieving this core function for many years.

LMHD has contracted with an outside consultant to assist in the development of a plan of action and to address insurance billing processes and procedures. We anticipate several key changes taking place in the first quarter of FY 06, and are confident that resources expended will be returned in additional insurance collections.

Historically, LMHD has paid employees overtime, as needed, to key flu shot data into the system. Over the last three years, the demand for flu shots has increased from 9,000 to 23,000 shots, and data entry is taking longer. Our primary focus has been to ensure flu shot data were entered into the system and revenue collected before June 30, using the least amount of overtime possible. In the future, the Department will address the problem in a different manner by hiring temporary labor for the months of November through January. We believe we will need at least 2 full time equivalents for the 3-month period to have all flu shot data entered as performed. In addition, we have instituted internal controls to assure that all flu shot data are keyed into the system, and that all

monies collected are accounted for and posted. Because this is a major area of fee-for-service collection, we have placed appropriate resources to assure positive results.

While bar code technology does exist, in the case of flu shots, because the volume of data collected is large as well as unique to the flu shot patient, bar coding would not be beneficial. Bar coding would be beneficial only for the 5-digit CPT code.

The Board of Health, on an annual basis, approves LMHD's charge schedule. From time to time during past years, codes not on the original schedule were added and approved by the Board. In future, we will ask the Board to approve the charge schedule more often than annually. We also will seek Board approval to use published minimum fees, as suggested in authoritative support fee and coding guides. We currently use *MAG Mutual, 2005 Physicians Fee and Coding Guide*. If fees are added during the year, we will use minimum fees as suggested by the guide. If we choose to charge other than the minimum fee, we will take those fees to the Board as necessary.

Observation #4 - Quality Assurance Process

The Health Department's quality assurance (QA) function was reviewed. This was not intended to be an assessment of the QA effectiveness or compliance with prescribed procedures. Rather, it was only to gain an understanding of the QA function and role. Key issues that may impact the effectiveness of the QA function include the following.

- The QA team has been in place approximately two years. The responsibilities and duties are still evolving as personnel gain more understanding of the processes.
- Some aspects of billing functions have been incorporated into the QA reviews.
- The QA function is complex since it requires understanding many programs and the various guidelines.
- Program guidelines change and evolve, so the QA function has to be flexible to keep current.
- Human resource constraints may impact the ability to perform independent reviews of activity.

These issues are noted because QA is an integral component of a strong internal control structure.

Site Coordinators' Responsibilities

A specific opportunity was identified that may strengthen the quality assurance process. The QA policy requires a monthly review of activity by Site Coordinators. The following issues were identified with this requirement.

- Site Coordinators review their own sites, which may impair objectivity since they are not totally independent of the activity reviewed.
- The extent of the review may be impacted by the Site Coordinators experience and level of expertise.
- The QA team reviews the Site Coordinators reviews once or twice per year.

These issues may result in inconsistencies in the QA process at the sites, thus impairing its overall effectiveness.

Recommendations

Health Department personnel should take necessary actions to address the issues noted. Specific recommendations include the following.

- ✓ The quality assurance function can reasonably be expected to be more beneficial in the future as long as the proper resources, training, and support are provided. A strong QA function will help ensure compliance with policies and procedures, and can be beneficial in addressing data accuracy and integrity issues.

- ✓ The quality assurance function should be monitored to ensure it is performing effectively. This may require development / implementation of benchmarks and metrics. Comparisons to QA functions at other local health departments may also be beneficial. This should help determine if the proper resources, training, and support are being provided.

- ✓ Consideration should be given to assigning Coordinators to review sites other than their own. This will provide some independence and objectivity in the review.

- ✓ The necessity of standardized reporting forms and training should be determined. This will help ensure the Site Coordinators are consistent in the site reviews.

Health Department Response

A Continuous Quality Improvement (CQI) team has been established within LMHD. The Billing unit has been involved with CQI to the extent that billing and data collection are part of what has historically been a medical records function. We will continue to work with CQI to help improve billing activity data collection and data entry accuracies throughout the Department.

We will develop training guidelines for staff, both initially and on a follow-up or re-training basis, as problems are identified during the Quality Assurance process. Our training goal is to provide quarterly training to all related staff based on problems identified, while at the same time, addressing specialized training for individuals or teams as major mistakes are identified.

The Billing Office also is involved with the Staff Development Committee to identify training needs for all employees within the department, and to help develop training opportunities to address those needs. The Staff Development Committee also is working to create standards of productivity, as well as accountability measures, for the different disciplines within the department.

Appendix

The following are contained in the appendix:

Appendix A – Health Department Sites Visited

Appendix B – Services Matrix

Appendix C – Data Entry Test Results

These begin on the next page.

Appendix A – Sites Visited for Review

	Health Department Site / Location	Encounters reviewed
1	400 E. Gray - Field	1
2	Bridges of Hope - Neighborhood	2
3	Dixie Health Center	6
4	Family Health Center Portland	1
5	Healthy Child Care at 4-C's	2
6	Highview Health Center	4
7	Jefferson County Immunization Project	2
8	Jefferson County Tuberculosis Clinic	3
9	Jefferson County Lab	10
10	Jefferson County Lead Program	1
11	Middletown Health Center	7
12	Neighborhood Place East	6
13	Neighborhood Place L&N	1
14	Neighborhood Place So. Central	2
15	Neighborhood Place So. Jefferson	1
16	Neighborhood Place Southwest (Cane Run)	2
17	Neighborhood Place TJ Middle School	3
18	Newburg Health Center	5
19	Specialty Clinic	9
		68